

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **44159**

JAN 22 1940
Registration District No. **75**

Primary Registration District No. **6162**

Registrar's No. **300**

1. PLACE OF DEATH:

(a) County Vernon
(b) City or town Washington Townships
(c) Name of hospital or institution: State Hospital No 3
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 mos 5 days
(Specify whether
In this community years, months or days) 5

8. (a) PRINT FULL NAME William ARTHUR GIRTH

8. (b) If veteran, name war — 8. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Annie Flaherty GIRTH 6. (c) Age of husband or wife if alive Not known years
7. Birth date of deceased June 1915 1885
(Month) (Day) (Year)

8. AGE: Years 55 Months 5 Days 26 If less than one day
hr. min.

9. Birthplace Carthage, Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business —

12. Name William Girth

18. Birthplace Carthage, Mo
(City, town, or county) (State or foreign country)

14. Maiden name Not known

15. Birthplace Not known
(City, town, or county) (State or foreign country)

16. (a) Informant State Hospital Records

(b) Address Nevada, Mo

17. (a) Burial (b) Date thereof 12/15/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Springfield, Mo

18. (a) Signature of funeral director Martha Buchinger

(b) Address Nevada, Mo

19. (a) 12-15-40 (b) Allen V. Hays
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Greene
(c) City or town Springfield R# 9
(If outside city or town limits, write "RURAL")
(d) Street No. — (If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 15
year 1940 hour 7 minute 35 A.M.

21. I hereby certify that I attended the deceased from Oct 10/15 1940 to Dec 15/15 1940.
that I last saw him alive on Dec 14/15 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Arterio Sclerotic Heart Duration

Due to Disease

Due to —

Other conditions Alzheimers Disease
(Include pregnancy within 9 months of death)

Major findings: Of operations —

Of autopsy No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) —

(b) Date of occurrence —

(c) Where did injury occur? — (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? 175

While at work? (Specify type of place) (e) Means of injury —

23. Signature G. S. Waraich (M. D. or other) —

Address State Hospital Nevada Date signed 12/15/40

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.
working under my personal supervision.

Signed

Mark Leininger

Licensed Embalmer No. *2656*

P. O. Address *Nevada, Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.